

Dr. Brown

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH 55635-57

44090
STATE FILE NUMBER

Registration District No.

128

Primary Registration District No.

2000

Registrar's No.

1216

S. 300
v. 1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Greene			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Springfield TOWN			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Springfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Handley Hosp.		Length of stay in lb 4 Mo.		d. STREET ADDRESS (If outside, give location) 611 N. Park Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATRICIA Middle PAULINE Last PERKINS			4. DATE OF DEATH Month Dec. Day 19 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6 1957	9. AGE (In years last birthday) 4 Months 13 Days IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Springfield, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Wilbur F. Perkins		13b. MOTHER'S MAIDEN NAME Bertha Wright		14. NAME OF HUSBAND OR WIFE X	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, No (unknown)) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. No		17. INFORMANT Wilbur F. Perkins Address Springfield, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningococcemia, Waterhouse-Friedrichsen Disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 0571 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from Dec. 20, 1957 , to Dec. 20, 1957 and last saw her alive on Dec. 20, 1957 . Death occurred at 12 noon m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Lyman D. Brown M.D. (Degree or title)		22b. ADDRESS 311 1/2 College		22c. DATE SIGNED 12/21/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/20/57	23c. NAME OF CEMETERY OR CREMATORY Liberty Cemetery		23d. LOCATION (City, town, or county) Near, Springfield, Mo. (State)	
24. FUNERAL DIRECTOR H.H. Lohmeyer ADDRESS Springfield, Mo.		25. DATE RECD. BY LOCAL REG. 12-23-57		26. REGISTRAR'S SIGNATURE Edith Williamson	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *RH McCarver*

Licensed Embalmer No. *2727*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.